CANCERS OF EYELID: REPORT OF TWO CASES

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SUMMARY

There are four main types of eyelid cancer. Basal Cell Carcinoma that by far the most common (85% of cases). This is a tumour of older person, after 50 years. Its occurrence in a child must search for Basal Cell Hamartoma. Squamous Cell Carcinoma represents about 5% of cases. It can occur de novo or more frequently on precancerous lesions. Acquired immunosuppression, xeroderma pigmentosum and albinism predispose to the occurrence of this cancer. The Sebaceous Carcinoma represents a little less than 5% of cases. The third type may arise in the meibomian, Zeis or sebaceous glands. Its diagnosis is often delayed because of its seemingly benign clinical appearance. Malignant Melanoma is a rare tumour of the eyelids, less than 1% of cases. From two observations, one Basal Cell Carcinoma and one Squamous Cell carcinoma in HIV/AIDS context, we did a short review of the literature on eyelid cancer pathology.

INTRODUCTION

Clinical aspects of eyelid tumors are varied. Eyelid tumors are benign in their majority. Precancerous forms, led by actinic keratosis, are usually due to prolonged sun exposure (1, 2). The risk of progression to cancer is estimated at less than 0.1% per year. There are four main types of eyelid cancer (1-3):

- Basal Cell Carcinoma (BCC): 85% of cases;
- Squamous Cell Carcinoma (SCC): about 5% of cases;
- Sebaceous Carcinoma (SC): represents a little less than 5% of cases;
- Malignant Melanoma (MM): is a rare tumor of the eyelids, less than 1% of cases.

We made a short literature review of eyelid cancerous lesions from two observations. A HIV positive woman who was seen for a voluminous SCC; and a man suffering from a BCC.

CASE REPORT

Case One

A woman aged 48, HIV positive, was seen for a major left eyelid swelling lasting for almost a month. The exorabitation of left eye, the eye was completely redesigned; no more of its structures (conjunctiva, cornea, sclera, and lens) was recognizable. Everything looked like a pulpit mass, highly vascularized, the size of an orange, with a necrotic and purulent center.

There were 3 ipsilateral mandibular lymph nodes under the size of a small lemon.

Histological examination of a biopsy specimen was allowed to diagnose a SCC.

The clinical and paraclinical exams (MRI, abdominal ultrasound) did not show any metastasis. The diagnosis of eyelid SCC, stage T4N1M0 was retained. Given the size of this tumor, radiation therapy before surgery (exenteration) was advocated. The patient died a week after this diagnosis in an acute liver failure context.

Case Two

A man aged 60 years was seen for a non-traumatic wound of the lower right eyelid evolving for nearly two months. His review noted:
– a wound of the lower right eyelid was located on
the “gray line”, at the inner 1/3 of the eyelid. It was
the size of a piece of one euro cent with the shape of
the crater, the edges were more or less regular, the
center was highly vascularized and bleeding easily
with a complete fall of eyelashes (Figure 2).

Figure 2

– there were no locoregional lymphadenopathy
A complete resection was performed (total resection
of the internal quarter the eyelid covering the
lacrimal punctum). The extemporaneous histological
examination confirmed the healthiness of edges before
surgical suture, and cytological nature of the lesion
(BCC). The reconstruction of the eyelid was made
following the technique of “ Tenzel’s semicircular
flap”. The postoperative period was favorable; the
patient was followed two years.

LITERATURE REVIEW

The BCC is by far the most common eyelids
malignant tumor. The preferred locations are in
order of frequency the lower eyelid, the internal
canthus, upper lid and the outer canthus. The main
risk factor is cumulative sun exposure (1, 2-4). There
are many clinical presentations, the most common is
the ulcerated nodules pigmented or not followed by
the sclerodermiform. A fairly typical clinic element
of this cancer is the presence on its surface of beads-
shaped lesions (2-4). Treatment is sometimes very
large mutilating surgical resection. BCC almost never
has metastasis, but its locoregional mutilating power
can be very devastating (1, 3).

The SCC is much rarer than BCC; it can occur
de novo or more frequently on precancerous lesions
such as actinic keratosis, intra epidermal carcinoma,
radio dermatitis, burn scars or chronic inflammatory
lesions. The main location is the lower eyelid. Unlike
the BCC, SCC presents a real metastatic potential
which is proportional to the tumor thickness and
the degree of dermis invasion (1, 5). The extension
is typically done through lymphatics vessels or by
contiguity to the orbit. After a biopsy of the skin for the
diagnosis, complete surgical resection when possible
is the best therapeutic approach. Radiotherapy may
be an alternative in case of indication against surgery,
or due to a large orbital extension or metastasis.
Topical or systemic chemotherapy is adjuvant therapy
for very advanced lesions and patients suffering
from xeroderma pigmentosum. The prognosis is
related with tumor thickness. Tumors of less than
2 millimeters almost never metastasize; between 2
and 6 mm, the risk is about 4.5%; and 6 mm beyond
the risk reaches 15% (especially in cases of muscular
or periosteal infiltration) (1, 5, 6).

The MM is now the first fatal skin tumor.
However at the eyelid it remains a rare tumor. The
prognosis depends on both, the Breslow’s criteria on
the maximum thickness of the tumor and histological
Clark’s criteria (7, 8). MM may appear de novo as a
superficial nodul or evolve from a precancerous lesion
(lentigo melanoma) (1, 9). The superficial extension
is characterized by a marked tendency to spread of
atypical melanocytes in the epidermal thickness or
conjunctival epithelium. The wide surgical excision
is the mainstay of treatment. The immunotherapy
used in very specialized centers appears promising
(10).

SC represents a little less than 5% of malignant
tumors of the eyelid in the West, but is much more
common in China (1, 10, 11). It usually appears
goshawks 60 years. This cancer among women is
slightly more common, and sits in two thirds of cases
at the upper eyelid. It usually begins with a nodule
evoking a chalazion, which can eventually ulcerate
taking the appearance of a BCC. There is often the
notion of recurrent chalazion. This tumor is more
aggressive and often with an orbital and locoregional
extension. At stage of diagnosis, metastases are
present in 15-20% of cases. Pathological examination
must be systematic in the presence of a chalazion
after 50 years (12). The exenteration is the appropriate
treatment in 13% of cases often complemented by
radiotherapy.

The eyelid cancer is well known. The aging
population and attractiveness of repeated sun
exposure make it topical. Its management is changing,
especially with the arrival of the sentinel lymph
node technique (13). This technique allowed among
others decrease of lymph node dissection number
and improving some cancers prognosis.

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